Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SOUTH TEXAS HEALTH SYSTEM
3255 W PIONEER PKWY
ARLINGTON TX 76013

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
HIGHLANDS INSURANCE CO

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-09-9593-01

MFDR Date Received
JUNE 23, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Understanding that TWCC is wanting to move to a hospital reimbursement of a %-over Medicare, we have used that methodology in our calculation of fair and reasonable. Medicare would have reimbursed the provider at the base APC rate of $14,542.36 for APC # 0222. Allowing this at 200% would yield fair and reasonable allowance of $29,084.72. Based on their payment a supplemental payment is still due of $18,307.68 on the APC alone, at this time."

Amount in Dispute: $18,354.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In accordance with 28 TAC Section 134.403(f), the provider chose to submit two bills to the carrier, one for the procedure of CPT Code 63685 and another for the implants. Therefore, at that time, the provider chose the reimbursement methods – to be reimbursed pursuant to 28 TAC Section 134.403(f)(1)(B) for the procedure and pursuant to 28 TAC Section 134.403(g) for the implants. The provider never amended its bills to include the procedure and implants in one bill and, as such, cannot take the position during medical dispute that it is entitled to reimbursement at 200% of the MAR for the procedure. With regard to reimbursement for the procedure, the carrier contends that the provider is entitled to no more than $10,806.00 for CPT Code 63685 since it billed that amount. In the alternative, the carrier asserts that the provider is entitled to no more than 130% of the MAR for CPT Code 63685, regardless of the amount billed. With regard to reimbursement for the implants the carrier has denied reimbursement based on the provider's lack of documentation. The provider never submitted proof of the cost of the implants prior to the initial and reconsideration of the bills and has not, to date, provided the certification required by 28 TAC Section 134.403(g). As such the provider is not entitled to reimbursement."

Response Submitted by: Beverly L. Vaughn, 5501-A Balcones Dr. #104, Austin, TX 78731

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
October 17 – October 21, 2008	Outpatient Hospital Services	$18,354.68	$18,262.76

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement for guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated January 27, 2009; Reconsideration EOB is not dated:
   - W1 – W/C State Fee Schedule adjustment*
   - 57 – Payment denied/reduced because documentation does not support this level of service, this many services, this length of service, this dosage, or this day's supply.
   - 97 – Payment is included in the allowance for another service or procedure for this outpatient hospital procedure. Unbundling of institutional services.
   - W4 – No additional reimbursement on reconsideration.

Issues

1. Did the respondent support the insurance carrier's reasons for reduction or denial of services?
2. Are the disputed services subject to a contractual agreement between the parties to this dispute?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. What is the recommended payment amount for the services in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason code 57 – Payment denied/reduced because documentation does not support this level of service, this many services, this length of service, this dosage, or this day's supply. Review of the documentation submitted by the respondent does not support the denial reason.
2. Review of the submitted documentation finds no information to support a contractual agreement between the parties to this dispute.
3. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
4. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published annually in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

   - Procedure code 36415 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to §134.203, the Medical Fee Guideline for Professional Services. The

fee listed for this code in the applicable Medicare fee schedule is $3.00. 125% of this amount is $3.75. The recommended payment is $3.75.

- Procedure code 80048 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to §134.203, the Medical Fee Guideline for Professional Services. The fee listed for this code in the applicable Medicare fee schedule is $11.83. 125% of this amount is $14.79. The recommended payment is $14.79.
- Procedure code 85002 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to §134.203, the Medical Fee Guideline for Professional Services. The fee listed for this code in the applicable Medicare fee schedule is $6.29. 125% of this amount is $7.86. The recommended payment is $7.86.
- Procedure code 85025 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to §134.203, the Medical Fee Guideline for Professional Services. The fee listed for this code in the applicable Medicare fee schedule is $10.86. 125% of this amount is $13.57. The recommended payment is $13.57.
- Procedure code 85610 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to §134.203, the Medical Fee Guideline for Professional Services. The fee listed for this code in the applicable Medicare fee schedule is $5.49. 125% of this amount is $6.86. The recommended payment is $6.86.
- Procedure code 85730 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to §134.203, the Medical Fee Guideline for Professional Services. The fee listed for this code in the applicable Medicare fee schedule is $8.38. 125% of this amount is $10.48. The recommended payment is $10.48.
- Procedure code 81003 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to §134.203, the Medical Fee Guideline for Professional Services. The fee listed for this code in the applicable Medicare fee schedule is $3.14. 125% of this amount is $3.93. The recommended payment is $3.93.
- Procedure code 88300 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. This service is classified under APC 0433, which, per OPPS Addendum A, has a payment rate of $15.27. This amount multiplied by 60% yields an unadjusted labor-related amount of $9.16. This amount multiplied by the annual wage index for this facility of 0.9053 yields an adjusted labor-related amount of $8.29. The non-labor related portion is 40% of the APC rate or $6.11. The sum of the labor and non-labor related amounts is $14.40. The cost of this service does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total APC payment for this service, including outliers, is $14.40. This amount multiplied by 200% yields a MAR of $28.80.
- Procedure code 63685 has a status indicator of S, which denotes a significant procedure not subject to multiple procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 0222, which, per OPPS Addendum A, has a payment rate of $15,337.45. This amount multiplied by 60% yields an unadjusted labor-related amount of $9,202.47. This amount multiplied by the annual wage index for this facility of 0.9053 yields an adjusted labor-related amount of $8,331.00. The non-labor related portion is 40% of the APC rate or $6,134.98. The sum of the labor and non-labor related amounts is

$14,465.98. If the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $1,575, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.194. This ratio multiplied by the billed charge of $1,806.00 yields a cost of $350.36. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for this service of $14,465.98 divided by the sum of all APC payments is 99.74%. The sum of all packaged costs is $9,064.65. The allocated portion of packaged costs is $9,041.04. This amount added to the service cost yields a total cost of $9,391.40. The cost of this service exceeds the annual fixed-dollar threshold of $1,575. The amount by which the cost exceeds 1.75 times the OPPS payment is $0.00. The total APC payment for this service, including outliers, is $14,465.98. This amount multiplied by 200% yields a MAR of $28,931.95.

- Procedure code J0690 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J2001 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J2250 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code 93005 has a status indicator of S, which denotes a significant procedure not subject to multiple procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 0099, which, per OPPS Addendum A, has a payment rate of $24.79. This amount multiplied by 60% yields an unadjusted labor-related amount of $14.87. This amount multiplied by the annual wage index for this facility of 0.9053 yields an adjusted labor-related amount of $13.47. The non-labor related portion is 40% of the APC rate or $9.92. The sum of the labor and non-labor related amounts is $23.38. The cost of this service does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total APC payment for this service, including outliers, is $23.38. This amount multiplied by 200% yields a MAR of $46.76.
- Procedure code C1894 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code C1787 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code C1820 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.

5. The total recommended payment for the services in dispute is $29,068.76 This amount less the amount previously paid by the insurance carrier of $10,806.00 leaves an amount due to the requestor of $18,262.76. .

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $18,125.95.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $18,125.95, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		August 9, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.